# Public Health Policy and Funding

- Discussion of
  - What is Public Health?
  - How has it evolved in the U.S.?
  - How is it organized?
  - How is it funded?
  - Challenges facing Public Health….

# Public Health Policy

- A Definition?

# Definition from 1920

- “the science and art of preventing disease, prolonging life, promoting physical health and efficiency through organized community efforts for the sanitation of the environment the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventitive treatment of disease, and the development of of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.” *Charles-Edward Amory Winslow*

  *Professor of Public Health, Yale*

# Intrusion into medical profession and industry

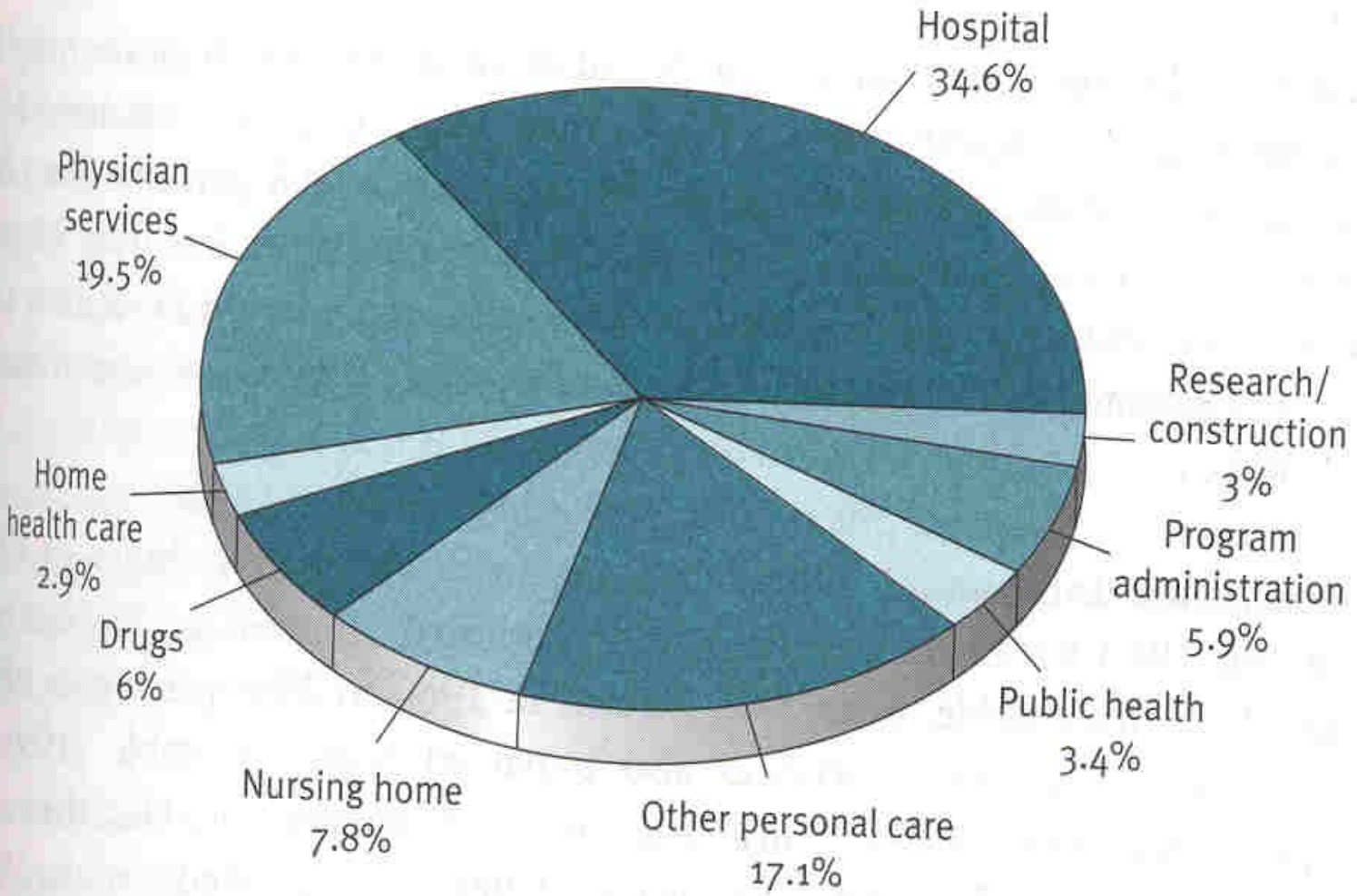
- Medical  profession did not embrace all of public health tenants and was threatened financially
- Industry felt economically threatened
- Public health was marginalized and relegated primarily to issues of sanitation

# Who pays for Public Health?

- States bear a disproportionate financial responsibility
- 1998 Public Health Activities expenditures as reported in Health Care Financing Review Winter 1999/Vol. 21, No. 2 demonstrate disparity

# 1998 Total Health Services vs Public Health Activities Expenditures

| All Health Expenditures ($B) | | Public Health Expenditures ($B) | |
|---|---|---|---|
| 1113.7 | Public & Private Sources | 36.6 | 3.3% |
| 500.4 | All Public Sources | 36.6 | 7.3% |
| 360.4 | Federal Sources | 4.2 | 1.2% |
| 140.0 | State & Local Sources | 32.4 | 23.1% |




NOTE: The category of "drugs" now includes only prescription drugs and "other personal care" includes dental, vision, and other.

SOURCE: HCFA Office of the Actuary

# Principal Features of Current U.S. Health Policy

- Government as subsidiary to private sector
- Fragmented, incremental and piecemeal reform
- Pluralistic and interest group politics
- Decentralized role of the States

# A CONTINUUM OF PUBLIC HEALTH ACTIVITIES FOR ALL AMERICANS

- "*For the last 20 years we've neglected public health,*" says Tennessee Senator Bill First, the Senate's only physician. The terrorist attacks have, "*shocked Americans into realizing how dependent we are on the system.*" *Time Magazine*, January, 21, 2002
- Strong, sustained support for the continuum of biomedical, behavioral and health services research, community-based prevention strategies, health care services for medically underserved populations, and health professions training is essential not only to enhance the nation's terrorism preparedness, but also to continue to improve the health and well-being of all Americans. Many public health needs are now being met through the programs of the U.S. Public Health Service*, which have played a key role in adding 35 of the 40 years of increased life expectancy for Americans in the past century. But new and continuing threats to the American public, such as bioterrorism, antimicrobial resistance, and chronic diseases, require, in a rapidly expanding global economy, the continued strong support of public health programs at the federal, state and local levels.

# Specific Public Health Challenges in the 21st Century Include

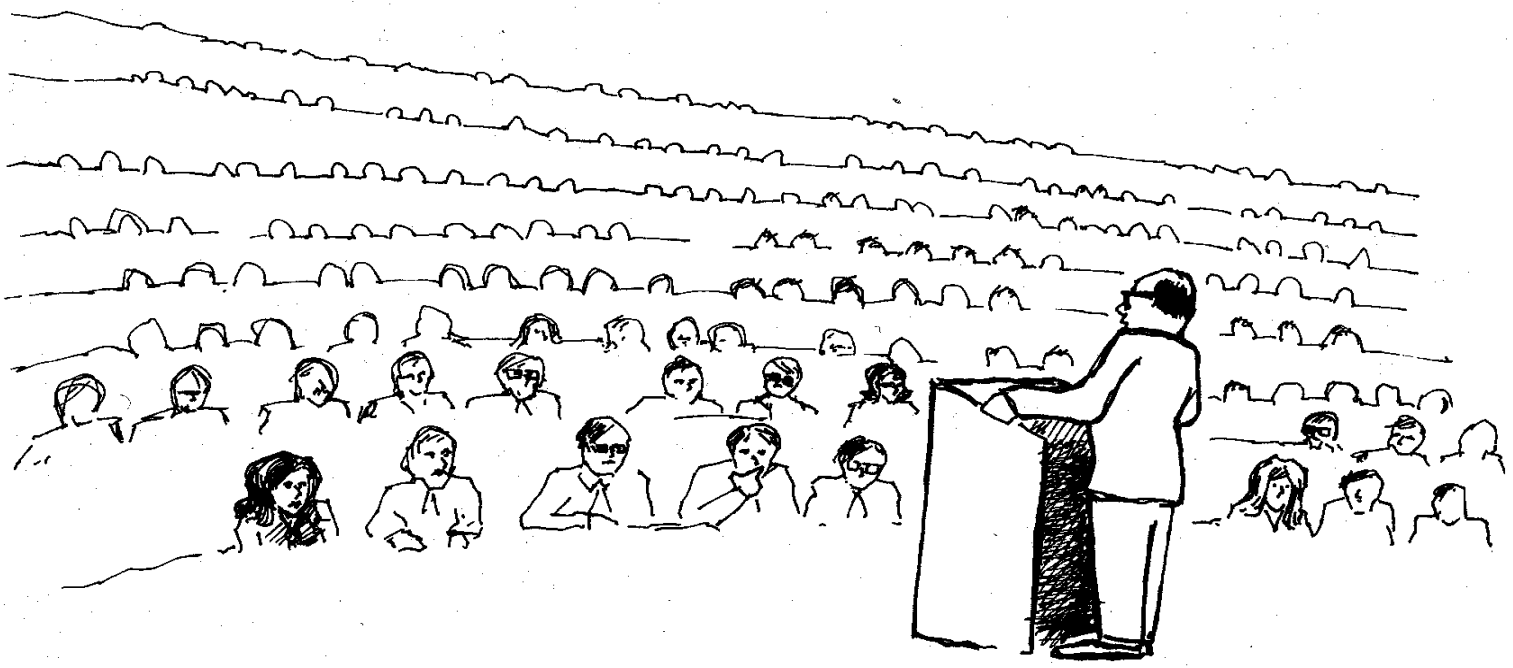
- Preparing for a terrorist attack involving biological, chemical or radiological agents
- Ensuring access for all Americans to needed health care services
- Eliminating health disparities
- Providing an appropriately trained health and public health workforce and in adequate numbers to address the breadth of need;
- Eliminating growing microbial resistance to drugs designed to treat common infections
- Ensuring a safe food supply and safe and effective drugs and medical devices
- Ensuring children and adults are vaccinated against preventable disease

# Specific Public Health Challenges in the 21st Century Include

- Preventing, or treating early, chronic diseases like heart disease, stroke, diabetes, and cancer
- Preventing, or treating early, infectious diseases like HIV/AIDS, and Hepatitis C
- Prevention unintended pregnancies and sexually transmitted infections
- Preventing birth defects like spina bifida and anencephaly
- Preventing and effectively treating serious mental disorders and substance abuse
- Preventing, or treating early, oral and dental disease, especially among children.

# Organization of Public Health Delivery

- Complex array of institutional and interorganizational structures
- No definitive division of labor



*"Ladies and Gentlemen, to come up with a uniform health policy, we will now break up into 31 different groups."*

# Federal Organizations Contributing to Public Health

- DHHS
- EPA
- FDA
- USDA
- CDC
- HRSA
- AHRQ
- IHS
- NIH
- ATSDR
- HCFA
- SAMHSA
- DoD
- DoA
- HUD
- DoE
- DoL

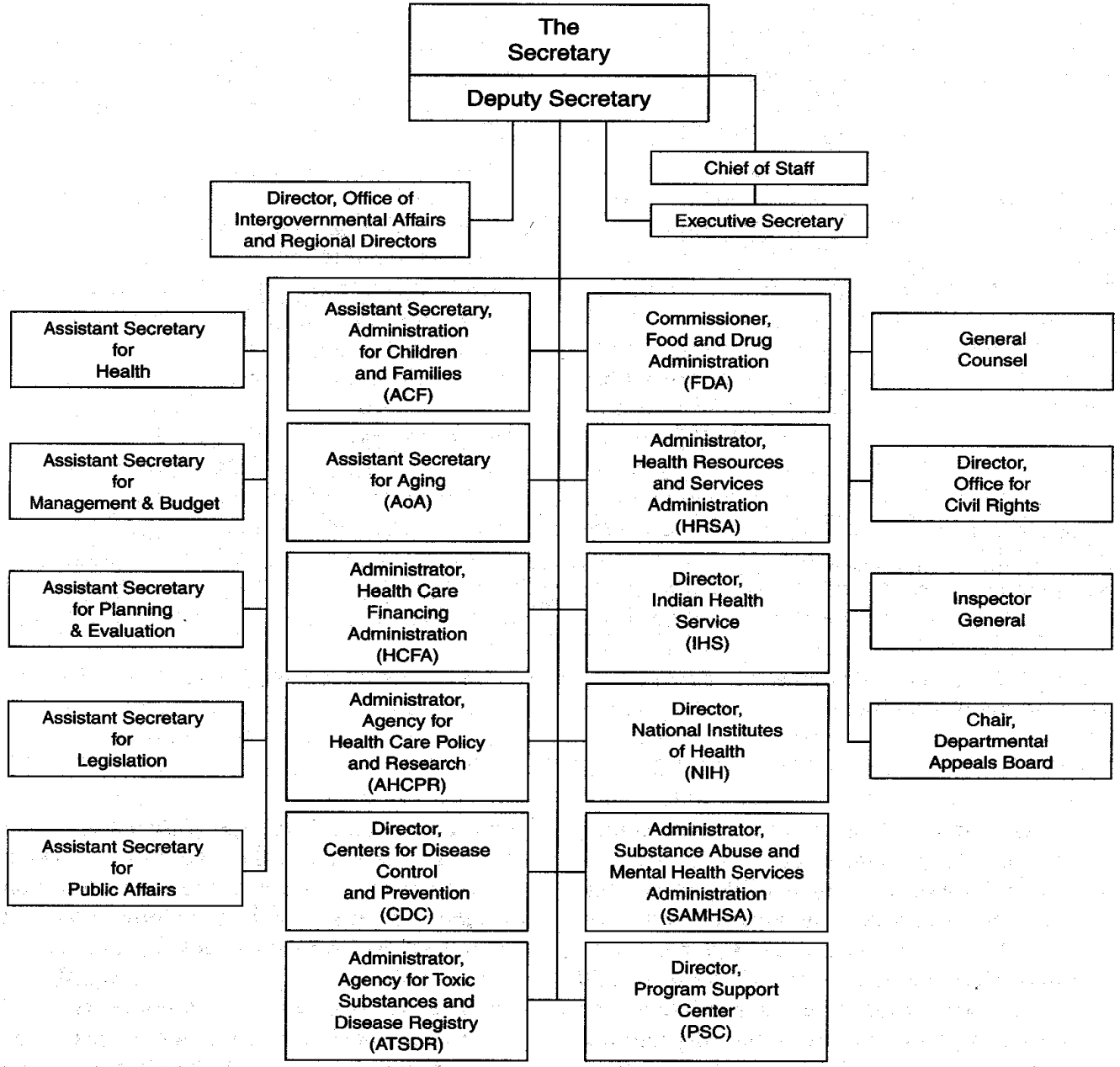

The Secretary
Deputy Secretary
Director, Office of Intergovernmental Affairs and Regional Directors
Chief of Staff
Executive Secretary
Assistant Secretary for Health
Assistant Secretary for Management & Budget
Assistant Secretary for Planning & Evaluation
Assistant Secretary for Legislation
Assistant Secretary for Public Affairs
Assistant Secretary, Administration for Children and Families (ACF)
Assistant Secretary for Aging (AoA)
Administrator, Health Care Financing Administration (HCFA)
Administrator, Agency for Health Care Policy and Research (AHCPR)
Director, Centers for Disease Control and Prevention (CDC)
Administrator, Agency for Toxic Substances and Disease Registry (ATSDR)
Commissioner, Food and Drug Administration (FDA)
Administrator, Health Resources and Services Administration (HRSA)
Director, Indian Health Service (IHS)
Director, National Institutes of Health (NIH)
Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)
Director, Program Support Center (PSC)
General Counsel
Director, Office for Civil Rights
Inspector General
Chair, Departmental Appeals Board

**Figure 3–1** Agencies within the U.S. Department of Health and Human Services. *Source:* U.S. Department of Health and Human Services.

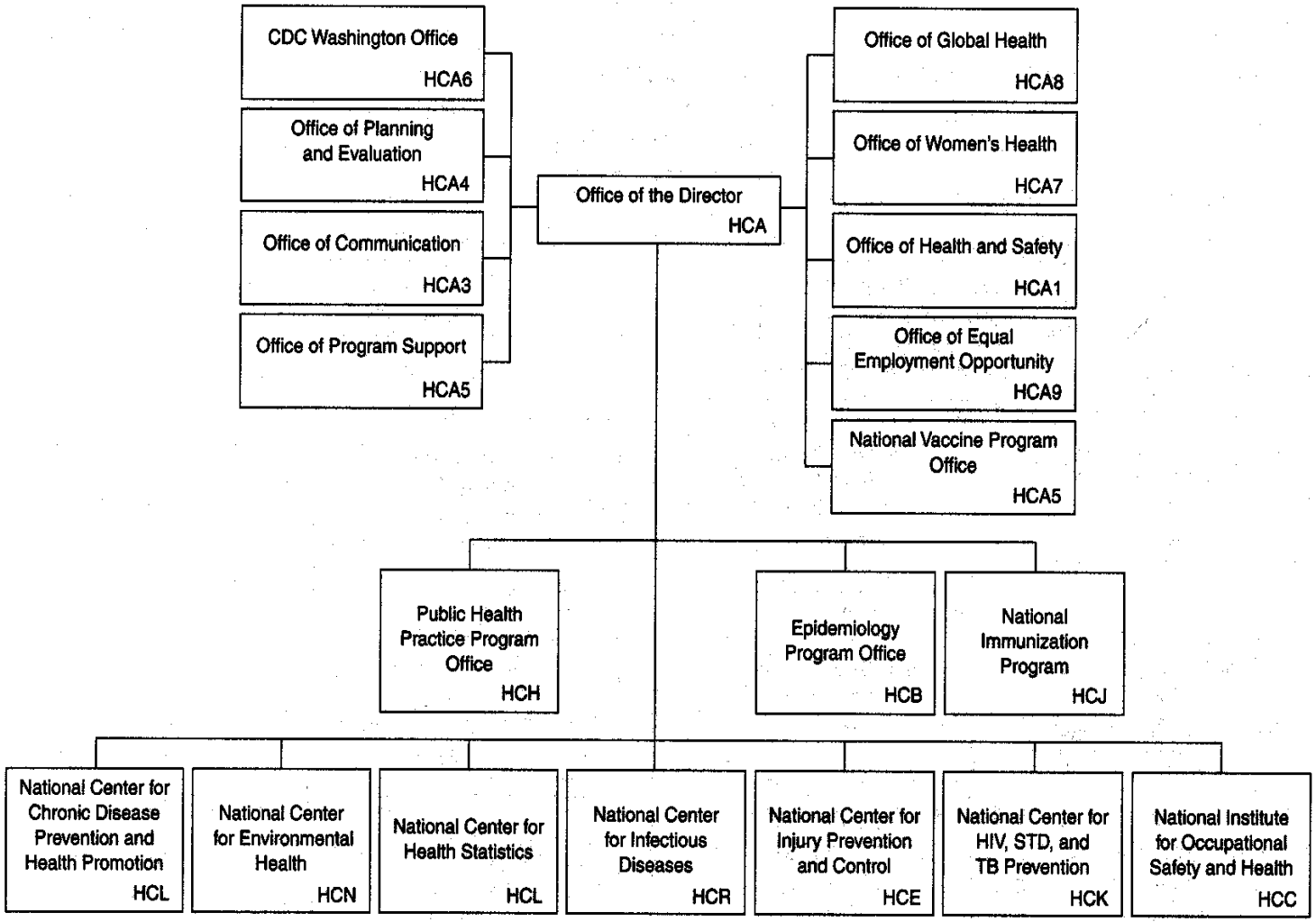



**Figure 3–2** Agencies within the U.S. Centers for Disease Control and Prevention. *Source:* U.S. Centers for Disease Control and Prevention.

# State Public Health Agencies

- Administration vs policy development and fund allocation
- Two primary organizational models
  - Freestanding agency
  - Agency within superagency
- Involved in community level program implementation in 98% of jurisdictions

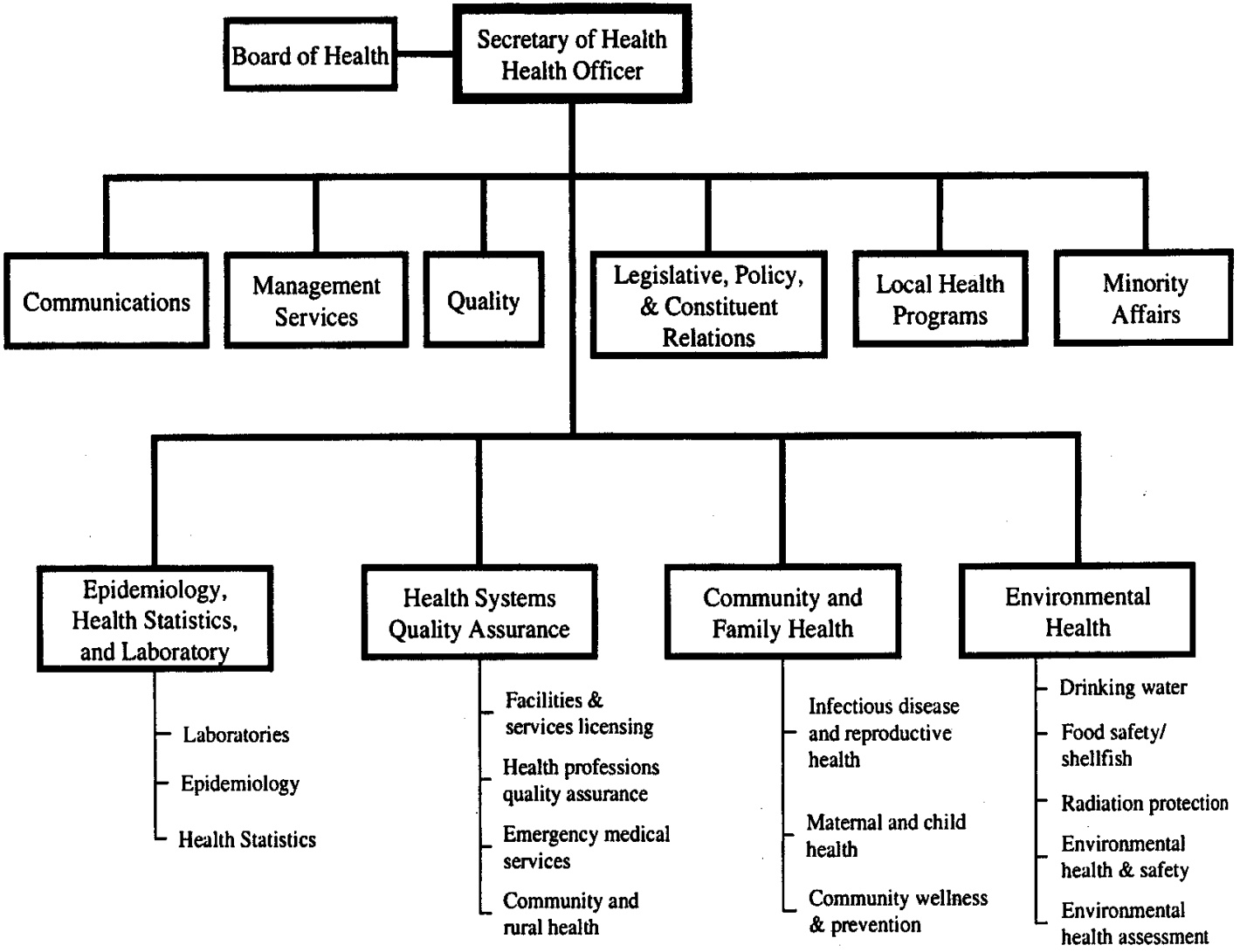



**Figure 3–3** Organizational Structure of a Free-Standing State Health Agency: Washington State Department of Health.

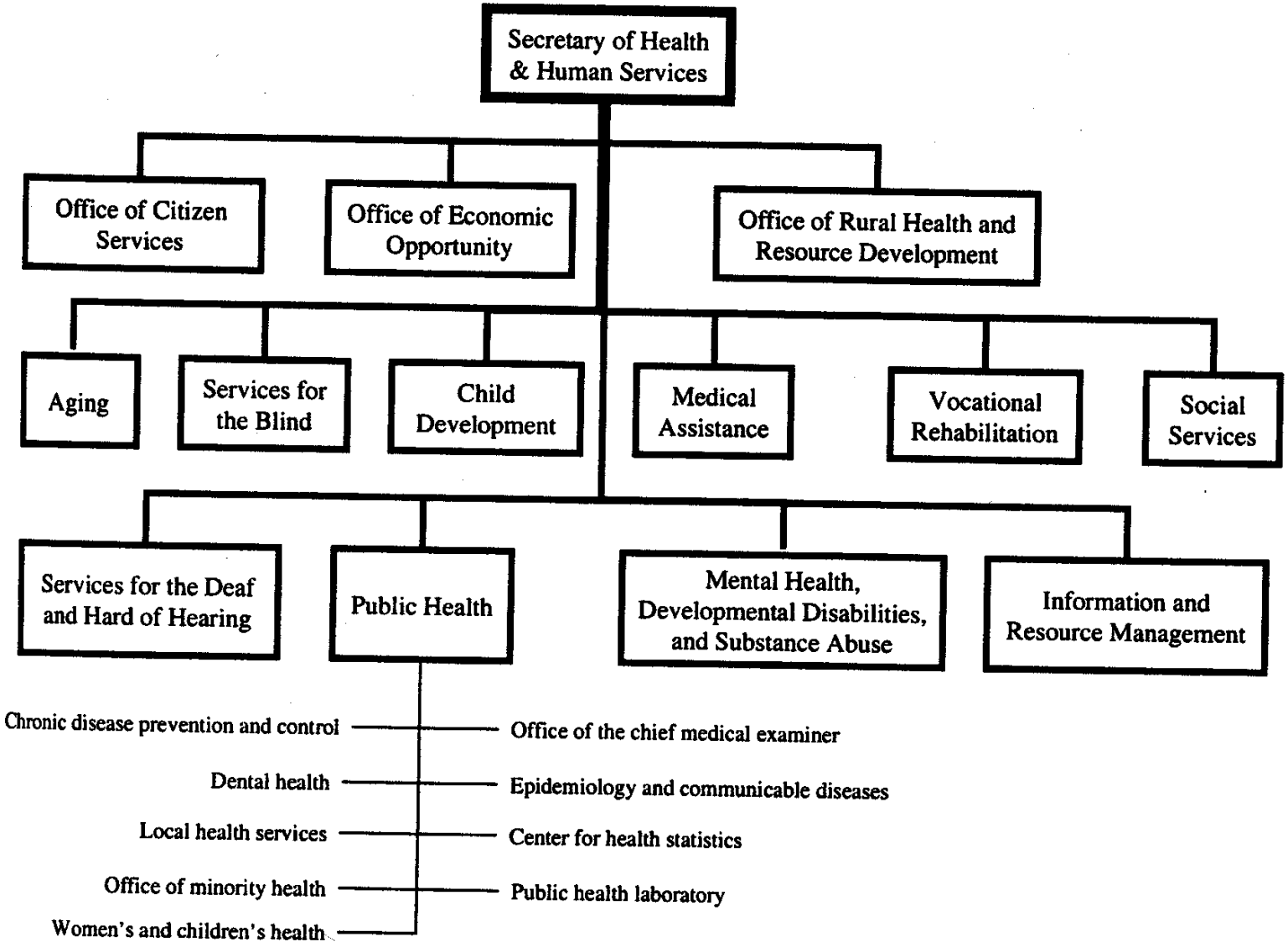



**Figure 3–4** Organizational Structure of a State Health Agency within a Super-Agency: North Carolina Department of Health and Human Services. *Source:* Data from North Carolina Department of Health and Human Services.

# Local Public Health Agencies

- Diverse organizational models
- Most are county or combined city-county agencies
- Operate in conjunction with local Board of Health
- “Fill in the gaps”
- In 1997 spent an average of $41/capita

**Exhibit 3–1** Characteristics of U.S. Local Health Departments, 1997

| | |
|---|---|
| Governmental Structure | |
| County departments (%) | 61 |
| City/town departments (%) | 18 |
| Multicounty/district departments (%) | 8 |
| Joint city–county departments (%) | 10 |
| Other (%) | 2 |
| Local Board of Health | |
| Board exists (%) | 81 |
| Board has policy-making authority (%) | 51 |
| Jurisdiction Served | |
| Less than 50,000 residents (%) | 66 |
| 50,000 to 500,000 residents (%) | 31 |
| More than 500,000 residents (%) | 4 |
| Average population size of jurisdiction | 99,354 |
| Median population size of jurisdiction | 30,000 |
| Financial Resources | |
| Average annual expenditures ($1,000s, 1996–97) | 5,508 |
| Median annual expenditures ($1,000s, 1996–97) | 690 |
| Average expenditures per capita ($) | 41 |
| Staffing | |
| Average full-time equivalent (FTE) staff | 71 |
| Median FTE staff | 16 |
| Average FTE staff per 100,000 residents | 151 |

*Source:* Data from National Association of County and City Health Officials (NACCHO), *1997 National Profile of Local Health Departments,* NACCHO.

# Organization of (Funding (disorganizati

- Follows structure of public health
  - Fragmented
  - Sometimes uncoordinated
  - Not glamorous enough to make public agenda
  - Little comprehensive planning
  - Reactive vs proactive

**Exhibit 17–1** Timeline for Public Health Financing Data Collection Activities

| | |
|---|---|
| 1923 | The American Public Health Association (APHA) Committee on Administrative Practice (CAP) collects expenditure data from 83 city and local health departments. |
| 1943 | The APHA CAP publishes *Health Practice Indices* that include budgetary information. |
| 1960 | The Health Care Financing Administration begins estimating public health expenditures based on census data and other local/state data sources. |
| 1970 | The National Public Health Program Reporting System is developed to collect longitudinal public health expenditure data. |
| 1990 | The National Association of City and County Health Officials (NACCHO) publishes estimates of national public health expenditures as part of the first *National Profile of Local Health Departments.* |
| 1991 | The Centers for Disease Control and Prevention (CDC) begins a study to estimate expenditures on health promotion and disease prevention activities. |
| 1992 | The Public Health Foundation issues an inventory of the block grant expenditures for state health departments. |
| 1993 | The CDC and NACCHO conduct a second survey of local health spending. |
| 1994 | The Public Health Foundation begins a series of studies to track expenditure data for state and local health departments. |
| 1995 | A second study by the Public Health Foundation in collaboration with the Public Health Service focuses on state health expenditures. |
| 1996 | Urban Institute's Assessing the New Federalism Project evaluates the public health system and its financing in 13 states. |
| 1997 | The Public Health Foundation in collaboration with the NACCHO and the National Association of Local Boards of Health evaluates local health spending. |

# Federal Funding Streams

- Appropriations to Agencies
- Grants

- Generally declining from peak in 1950s
- Highly variable

- Medicare and Medicaid provide little PH

# State Funding Streams

- Categorical grant and base funding
- Highly variable by state and methodology

# Local Funding Streams

- Local tax levies
- Permits and licensing fees
- Patient services revenue
- Reimbursement for indigent care
- Charitable giving and foundations

**Table 17–1** Sources of Local Health Department Expenditures

| *Funding Source* | *1991 Public Health Foundation Study* | *1992–93 CDC and NACCHO Study* |
|---|---|---|
| State funds | 28.1% | 40% |
| Local funds | 33.6% | 34% |
| Federal funds | 15.5% | 6% |
| Third-party reimbursements | 12.9% | 10% |
| Fines and fees | * | 7% |
| Other | 2.3% | 3% |
| Unknown | 7.6% | Not listed |
| Total | 100% | 100% |

*Fines and fees may be included in local funds or the unknown category, but were not specifically broken out during the study.

# Public Health Financing Challenges

- Loss of Medicaid revenue to managed care plans
- Privatization of PH services
- Cost competitiveness/awareness
- Increasing numbers of uninsured
- Information technology
- Declining grant funds
- Bioterrorism response